State Innovation Model 2016

May 2016

Patient Centered Health Advisory Council

National Case for Change

Shift from **Volume** to **Value**

What our system pays for:

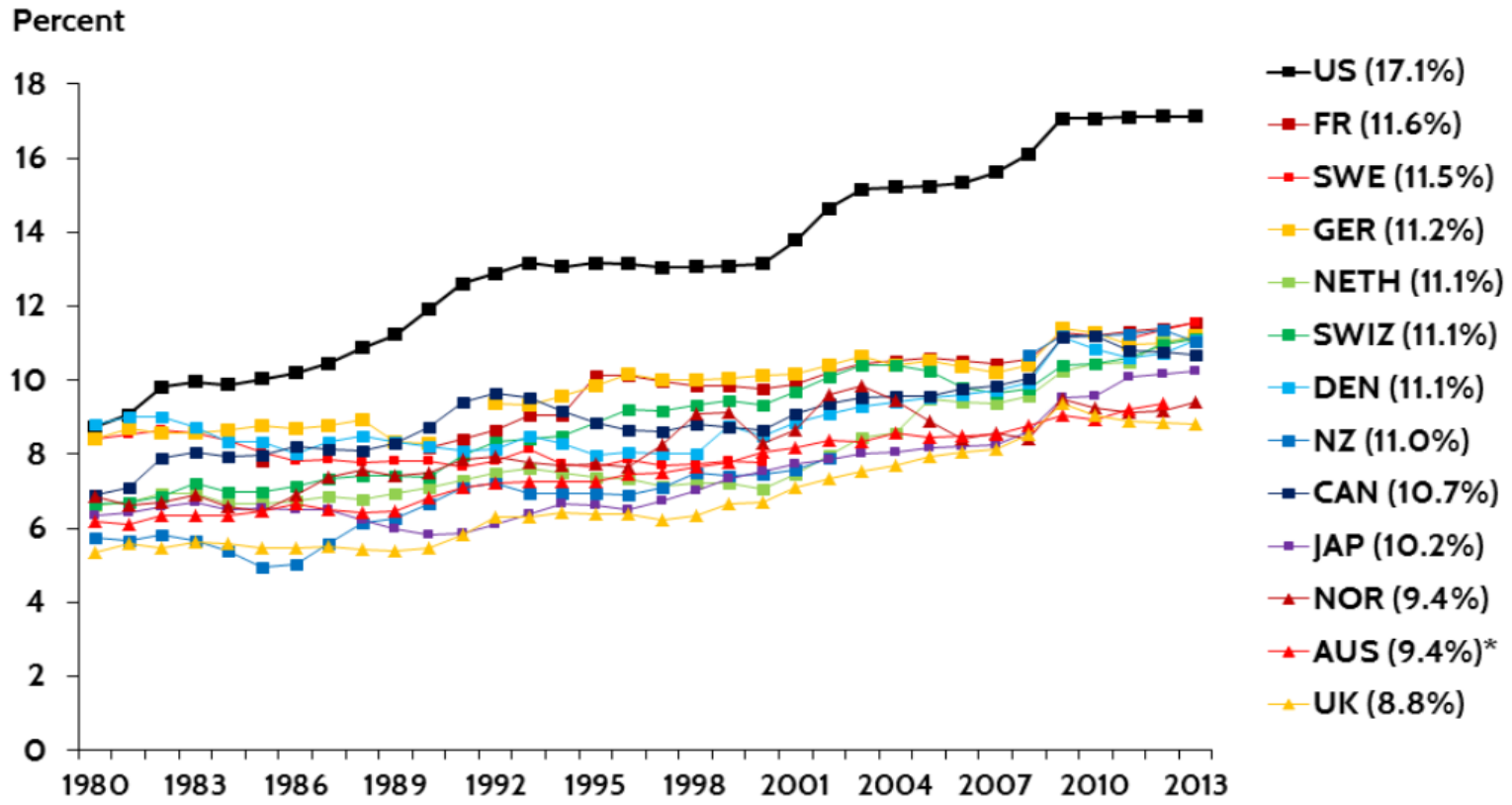
More Services

What we want to pay for:

Healthier People

National Healthcare Cost Comparison

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



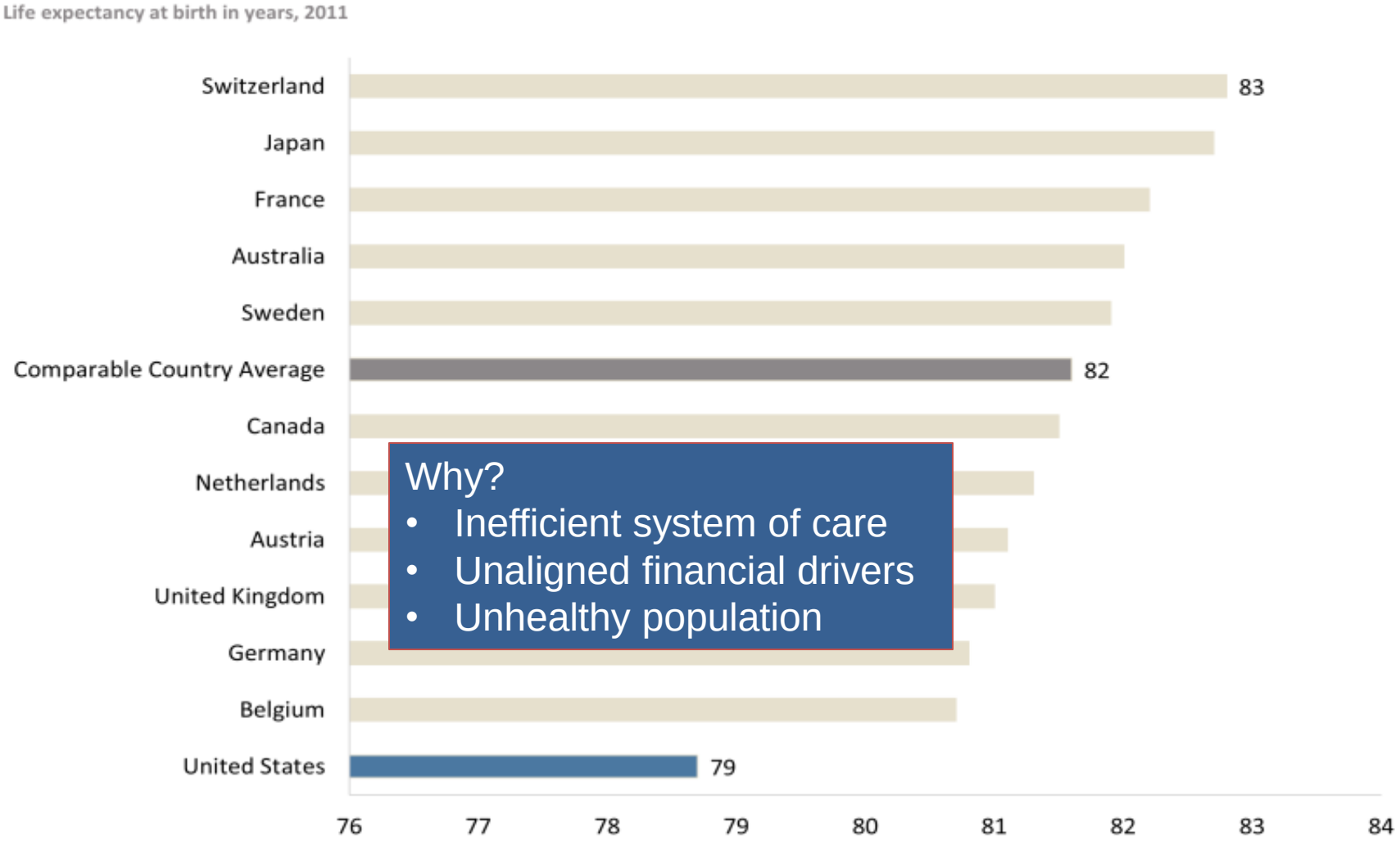
* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

National Trends

THE CONSEQUENCE OF INEFFICIENCY AND POOR HEALTH STATUS



Source: OECD (2013), "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database). doi: 10.1787/data-00349-en (Accessed on June, 25 2014).

Peterson-Kaiser Health System Tracker

Health and Human Services Sets the Stage for Change

Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care

Sylvia M. Burwell

New targets have been set for value-based payment: 85% of Medicare fee-for-service payments should be tied to quality or value by 2016, and 30% of Medicare payments should be tied to quality or value through alternative payment models by 2016 (50% by 2018).

Source: New England Journal of Medicine:
U.S. Dept. of Health and Human Services Secretary Sylvia M. Burwell

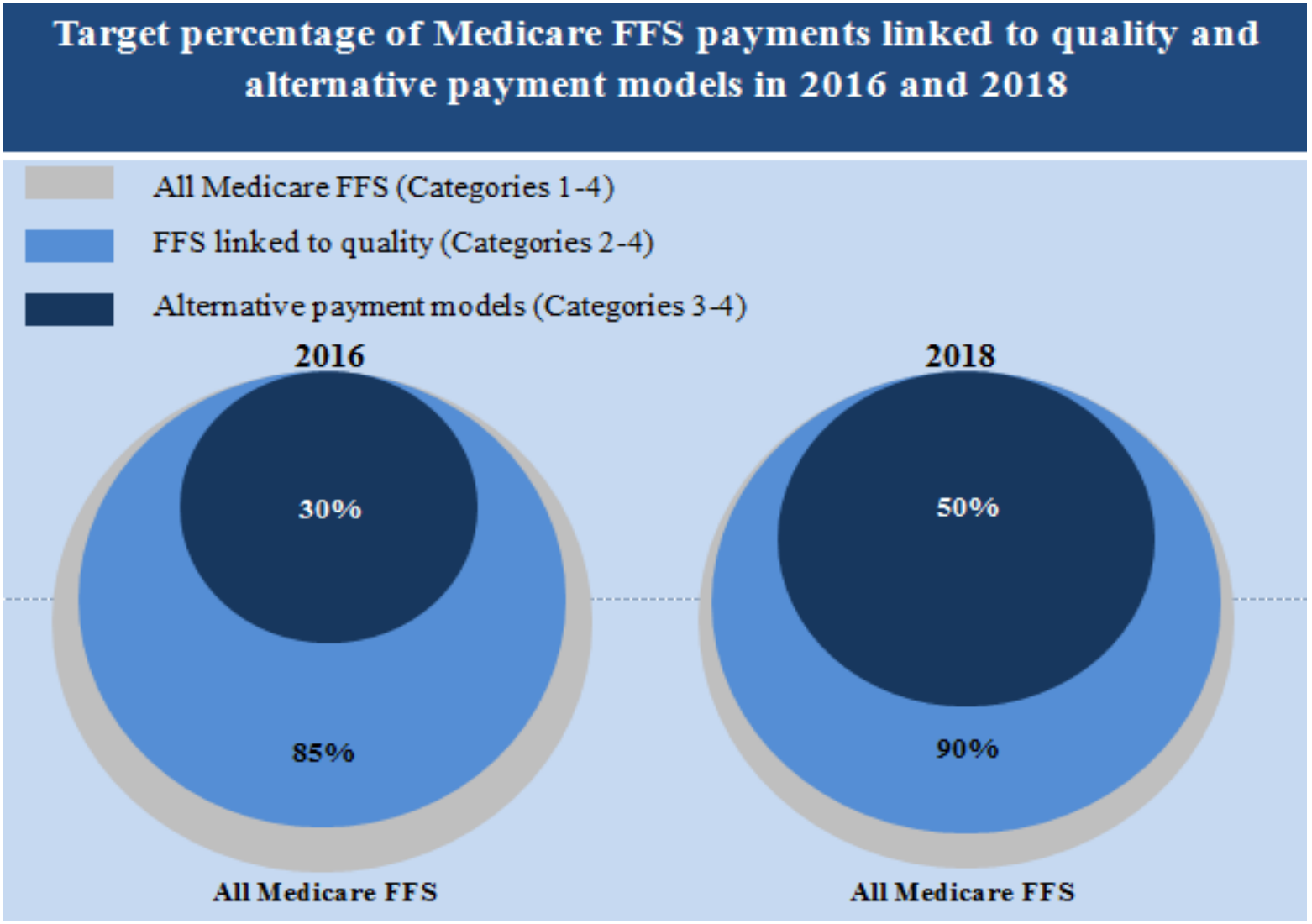
Triple AIM

Secretary Burwell's announcement is focused on achieving:

- Better Care
- Smarter Spending
- Healthier People

- Three Strategies to Drive Progress
  1. Incentives to reward high-quality health care
  2. Improving the way care is delivered
  3. Accelerate availability of information to guide decision making

CMS goals to move to Value

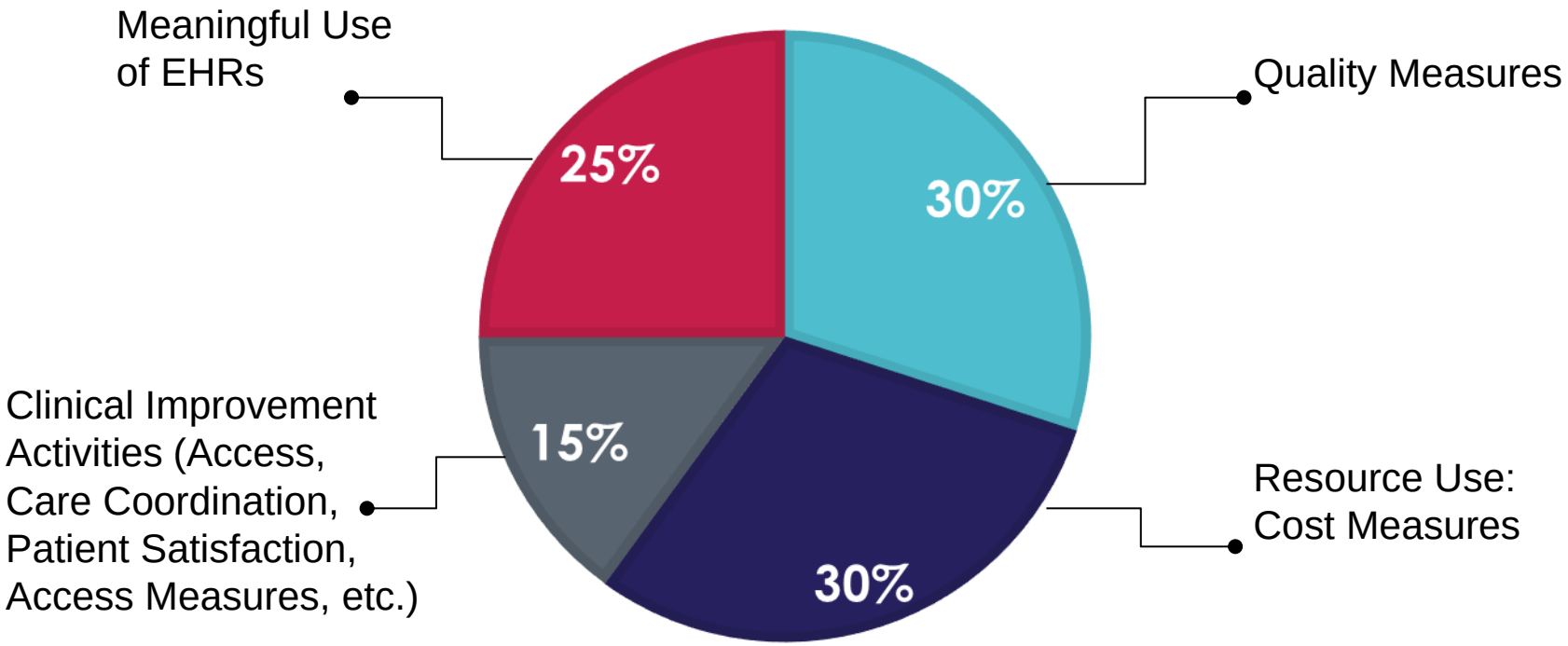


Better Care, Smarter Spending, Healthier People

"All alternative payment models and payment reforms that seek to deliver better care at lower cost share a common pathway for success: ***providers must make fundamental changes in their day-to-day operations that improve the quality and reduce the cost of health care.***"

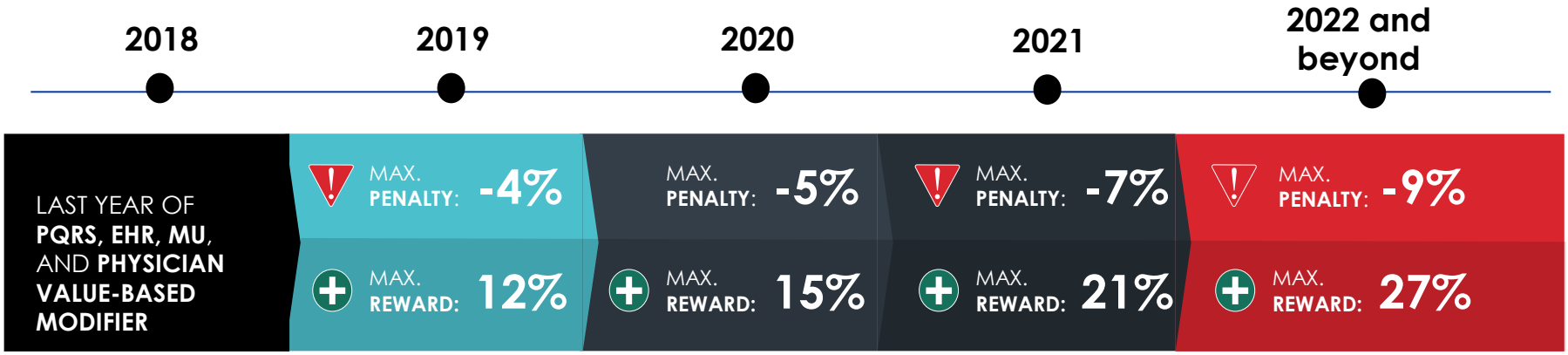
Merit-Based Incentive Payment System (MIPS)

PQRS, MU and VM combine into a single payment adjustment



Source: The Medicare Access & CHIP Reauthorization Act of 2015.

Merit-Based Incentive Payment System (MIPS)



Source: The Medicare Access & CHIP Reauthorization Act of 2015.

Alternative Payment Model (APM)

Definition of APM

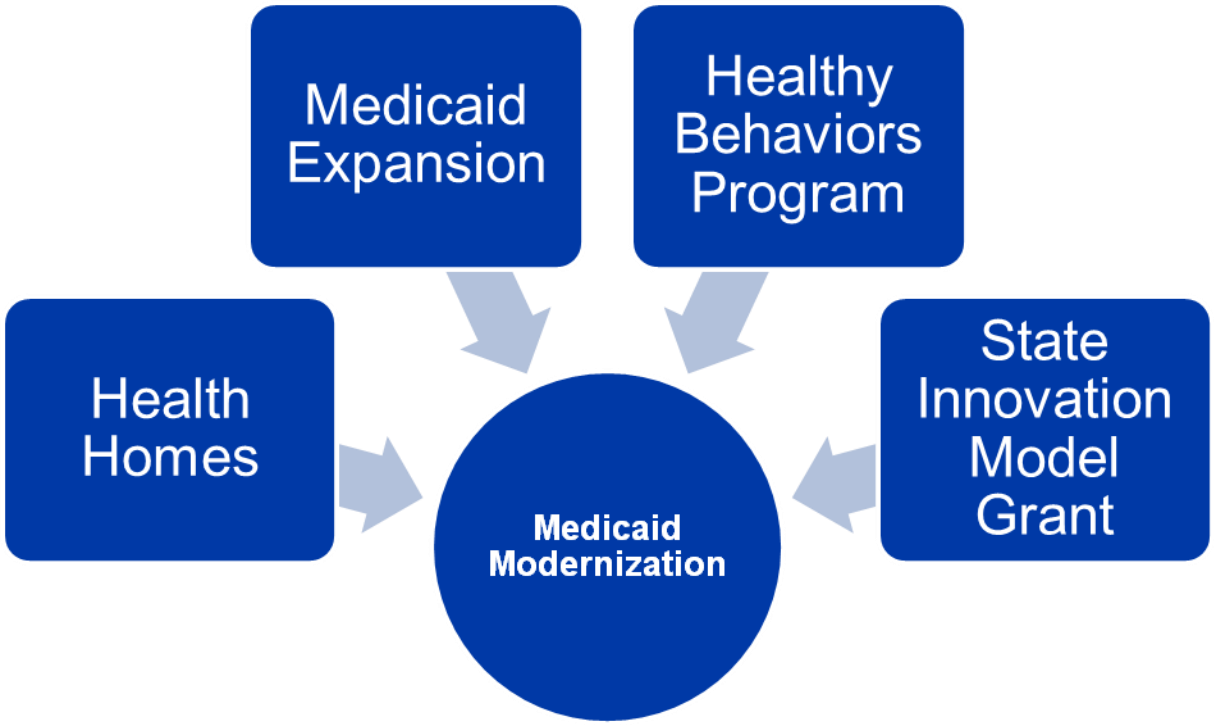
- A Center for Medicare and Medicaid Innovation (CMMI) Model,
- A Medicare Shared Savings Program Accountable Care Organizations (ACO), and/or,
- A similar CMS demonstration model.

Requirements

- Participate in a defined APM and meet additional criteria of an eligible alternative payment entity, such as using certified EHR technology.
- Meet established thresholds.

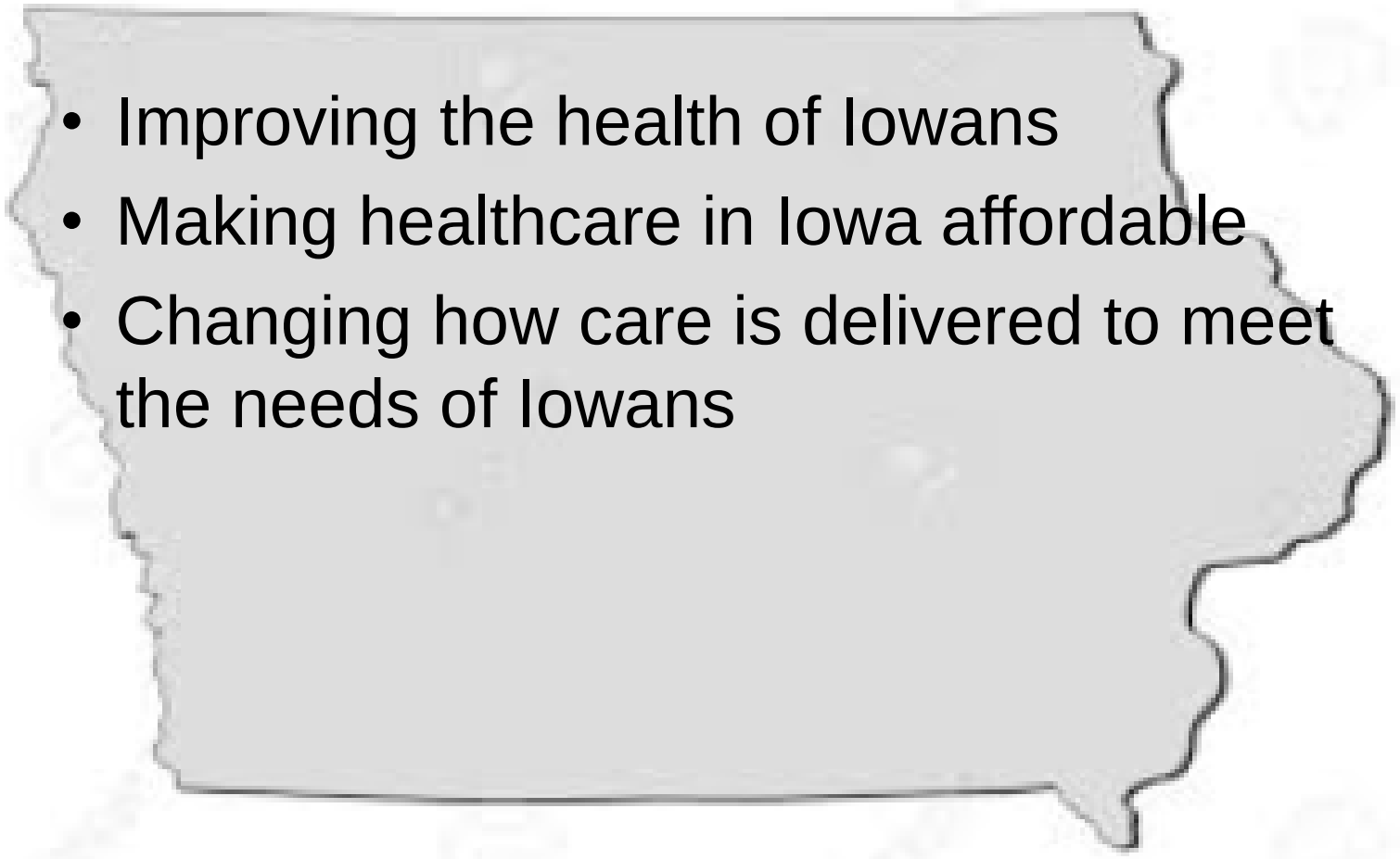
Iowa's SIM

Using Innovation to Address a Changing and Growing Program



SIM is a Statewide Initiative

Payers, Providers, Public Health, Populations working together towards common outcomes

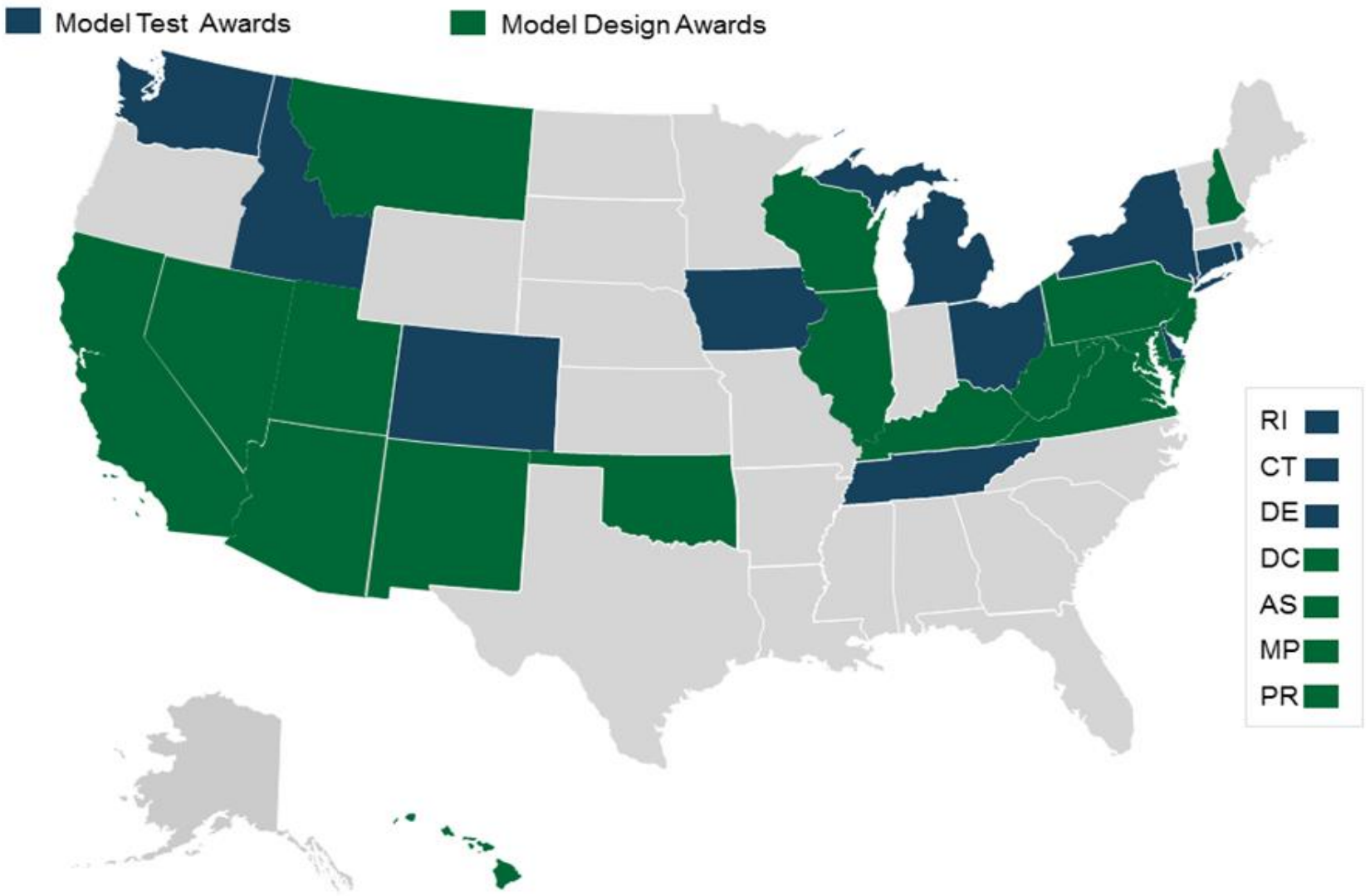


- Improving the health of Iowans
- Making healthcare in Iowa affordable
- Changing how care is delivered to meet the needs of Iowans

State Innovation Model (SIM)

- Iowa is one of 11 Round Two Test States
  - 1 implementation year and 3 model test years
  - 43.1 million dollars to test innovations that achieve our SIM vision
- **Broad-based, multi-payer approach that improves health for <u>all Iowans</u>**
  - Involve innovative approaches that encompass private-public partnerships
  - Population health improvement and payment reforms

Round 2 SIM Awards



Source: Centers for Medicare & Medicaid Services

SIM Goals

By 2018 the SIM will:

- **Increase** the percentage of adults smokers who have made a **quit attempt** by 5.1%
- **Decrease** the **adult obesity** prevalence rates by 2.9%
- **Increase** the percent of adults with diabetes having two or more **A1c tests** by 4.1%
- **Reduce** preventable **ED Visits** by 20%
- **Reduce** preventable **Readmissions** by 20%
- **Increase** amount of healthcare **payments linked to value** to reach 50%

Major Accomplishments in Year 1

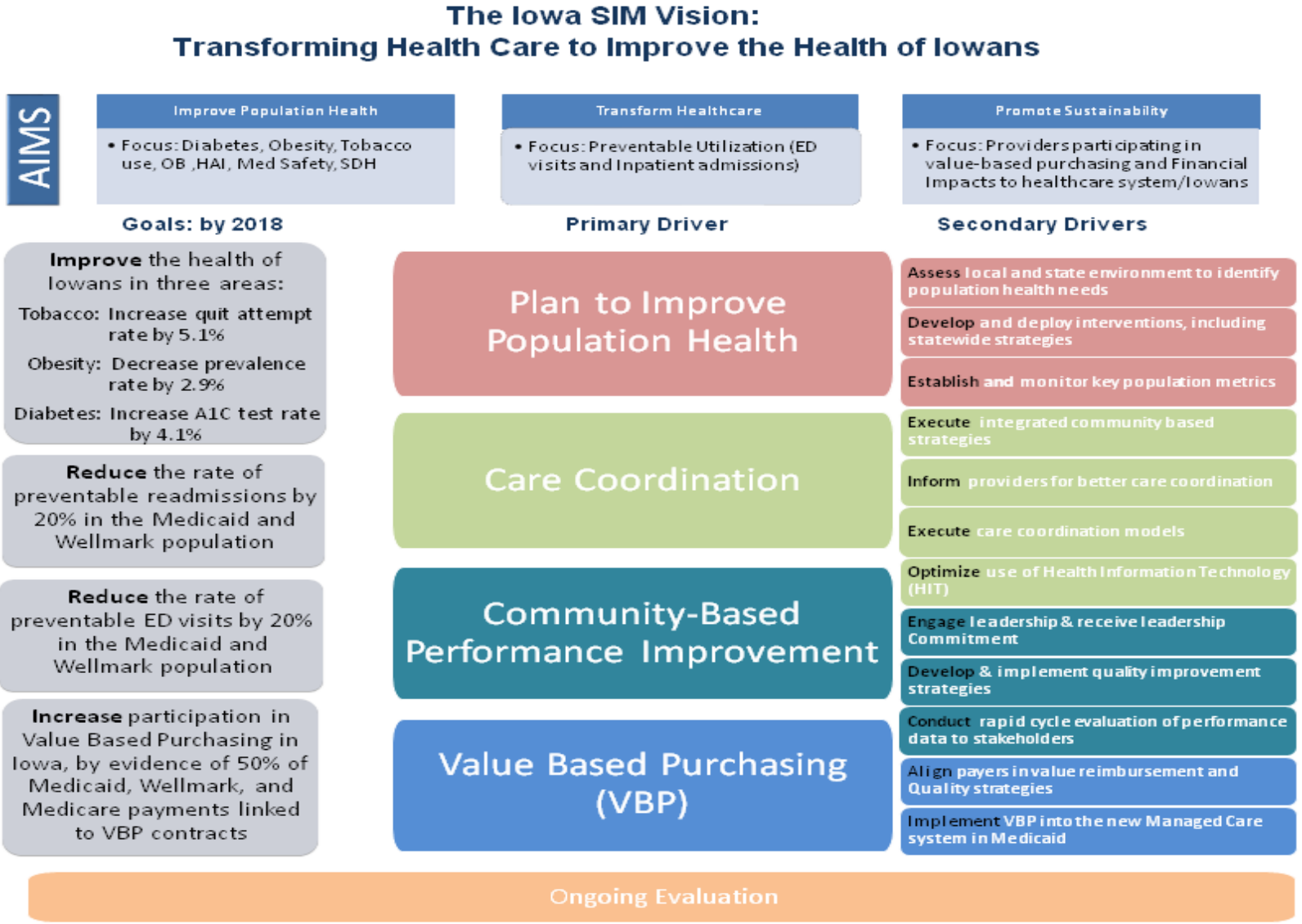
- Ensured key, strategic SIM project concepts were in Iowa's final revision of the managed care RFP
  - Value Index Score (VIS) and Total Cost of Care (TCOC)
  - Goal that 40% of their covered lives in a Value Based Purchasing (VBP) arrangement by 2018.
- Completed all vendor contracts and hired staff to support activities planned for 2016
- Statewide SIM Learning Community on August 18, 2015

Major Accomplishments in Year 1

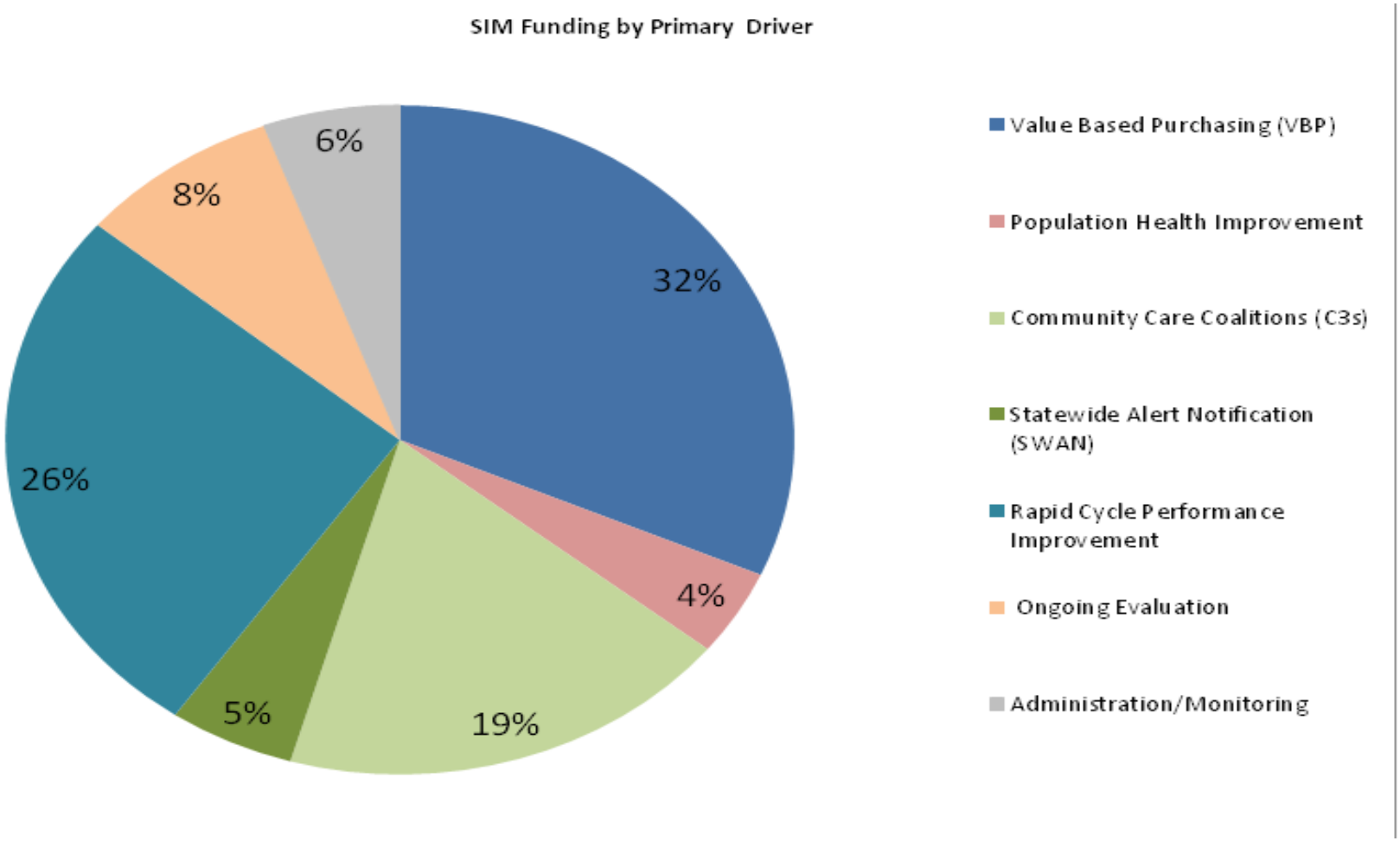
- CMMI Approval of 2016 Operational Plan
- Released, reviewed, and awarded six C3 applications for community-based performance improvements
- Refreshed the VIS Online dashboard 8 times
- Successfully launched the Statewide Alert Notification (SWAN) System
- Redesigned the state SIM website that is closely linked with IDPH and IHC

  http://dhs.iowa.gov/ime/about/initiatives/newSIMhome

Driver Diagram



Budget Drivers



Value-Based Purchasing (VBP)

Two SIM strategies to align VBP in Iowa:

1. Implement VBP in Medicaid Managed Care
   - Support ACOs and other value oriented providers engaged in Medicaid VBP models
2. Align value reimbursement and quality models across payers
   - Ensure ACOs and providers are getting to scale on transformation to improve the health of all Iowans

Value-Based Purchasing Models

Medicaid, using MCO oversight, will ensure value-based activities align in Iowa

- Each MCO shall:
  - Support the SIM grant activities
  - Each MCO shall use a value-based purchasing model for at least 40% of population by 2018
  - Each MCO shall use the Value Index Score (VIS)

IME's Definition of VBP

https://dhs.iowa.gov/sites/default/files/VBP_Models_Definition_and_Qualifying_Criteria_for_Determining_Eligible_Models.pdf

Value-Based Payment (VBP) Models Definition and Qualifying Criteria for Determining Eligible Models

Purpose of the Definition: A definition of VBP is necessary to support the objectives of the State Innovation Model and to guide Medicaid in approving VBP models proposed by Managed Care Organizations (MCOs) to be used to achieve the requirement of "40% of covered lives within a VBP model".

RFP VBP Definition: Linking provider payment to improved performance by health care providers is called Value Based Purchasing. This form of payment holds health care providers accountable for both the cost and quality of care they provide. It attempts to reduce inappropriate care and to identify and reward the best-performing providers, in a way consistent with overarching goals announced by the U.S. Department of Health and Human Services on January 26, 2015.

VBP Operational Guidance for MCOs: The VBP models implemented by MCOS shall include but are not limited to risk sharing including both shared savings and shared costs between the MCO and the participating provider organizations, and bonus payments to providers for improved quality on a population basis.

Both the bonus payment for improved quality and any risk sharing shall be evaluated using a Total Cost of Care (TCOC) methodology and the state's approved set of risk adjusted quality measures called Value Index Score (VIS).

A TCOC calculation at a minimum includes a comprehensive set of services approved by the state that spans across the continuum of care, including inpatient, outpatient, pharmacy, mental health, and Long Term Care Supports and Services (LTSS).

Examples of Qualifying VBP models:

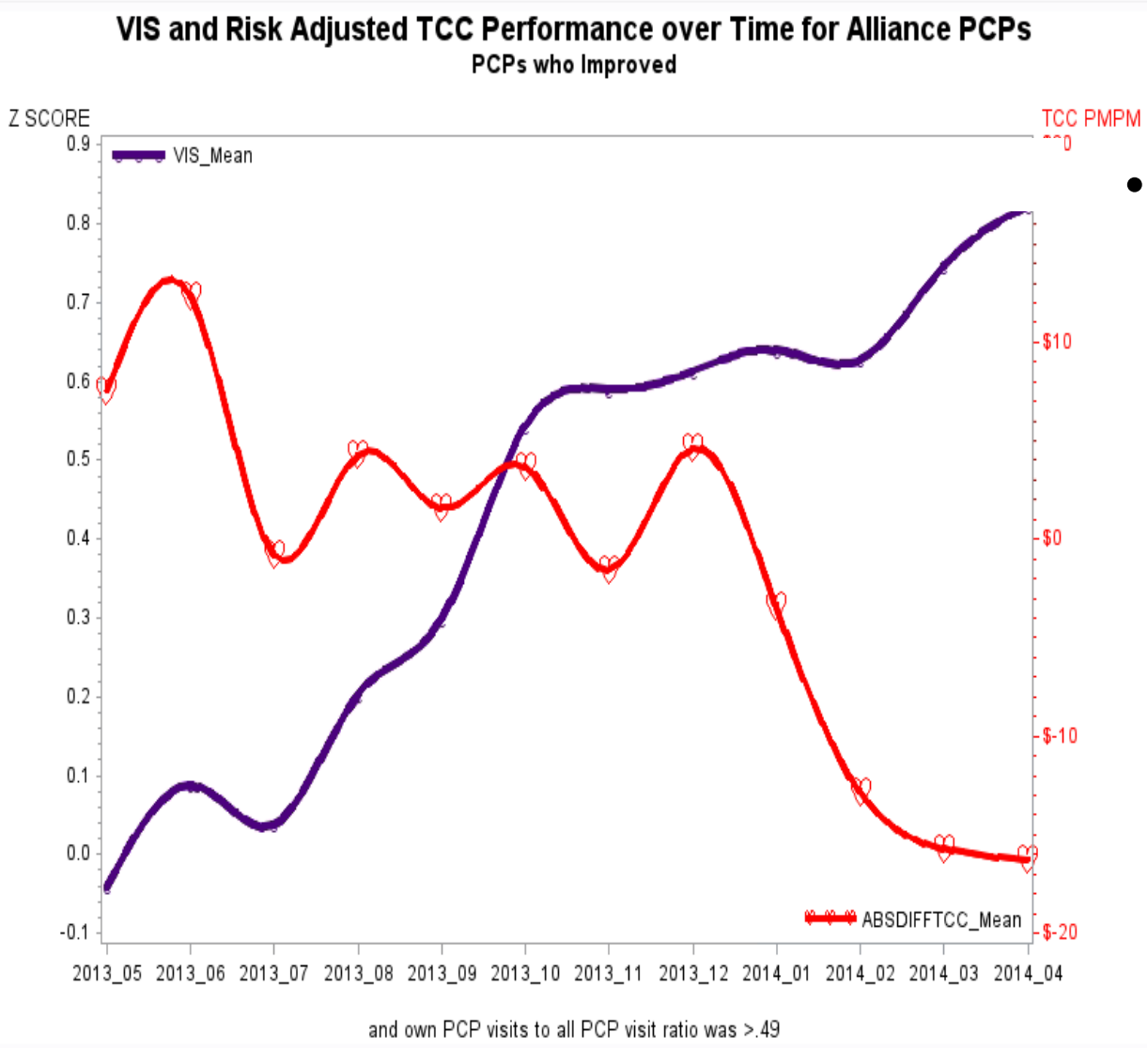
- Shared Savings/Shared Risk contract with an MCO, which tracks TCOC and quality for a defined population of attributed members. (e.g., Accountable Care Organizations, Bundled Payments). Quality must either improve or remain constant during the reporting period.
- Upfront care coordination payments for a specific population assigned, with the intent of achieving a specific outcome, a risk-based component of that up-front payment could be included if quality and TCOC results are not realized. (e.g., Health Homes)

Value-Based Purchasing Models

Medicaid will support ACO and other value oriented provider networks engaged in VBP models

- Sharing claims data
- Sharing quality reporting
- Sharing real-time alerts during critical transitions of care

Iowa Medicaid VIS Results



- PCPs that improved their VIS score over a 12 month period also lowered their total cost of care during that same period

Iowa Wellness Plan ACO Outcomes

- At the end of 2015,
  - **11%** of Medicaid lives attributed to an ACO agreement (Iowa Wellness plan)
  - **51%** of ACO members achieved at least one healthy behavior, and on average 28% achieved both healthy behaviors.
  - In comparison, for the regular Medicaid population, only **5%** completed the wellness exam.

Iowa Wellness Plan ACO Outcomes

- Medicaid paid out $430,000 in VIS bonuses in 2014
  - PCPs in an ACO were **5%** more likely to earn a VIS bonus than non ACO PCPs.
  - compiled VIS score for PCPs in a VBP arrangement was **58.7%**
  - Compiled VIS score for PCPs NOT in VBP arrangement was **37.7%**

SIM Partners

SIM Website
http://dhs.iowa.gov/ime/about/initiatives/newSIMhome

Iowa Healthcare Collaborative

IDPH

Iowa Department of Human Services

healthiest state initiative